MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

REQUEST FOR CERTIFICATION

Completion of this form indicates that the rehabilitation provider is interested in being contacted by the Division regarding certification.

General Information:

Facility Name: _____

Address: _____

_____

******* For multi-site facilities, please attach a list of all locations.***

Contact Person: _____

Phone: _____ Fax: _____

Medical Director: _____ Years of Experience: _____

Date Facility Established: _____ Type of Facility: ☐ Inpatient ☐ Outpatient

List date of latest certification *(if applicable)*:

JCAHO _____ CARF _____ Medicare _____ Other *(specify)* _____

Has facility ever been certified by the Division? ☐ Yes ☐ No If "Yes," please provide date: _____

What percentage of your client base is workers' compensation? _____

_____
Signature of person completing form

_____ _____
Title *Date*

Return completed form to:

Fax: 573-522-1623

Phone: 573-526-3876

Mail: Attn: Rhonda Forck
Missouri Division of Workers' Compensation
P. O. Box 58
Jefferson City, Missouri 65102-0058